JOE LOMBARDO
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES

RICHARD WHITLEY, MS
Director

ROBERT THOMPSON
Administrator

☐ TANF ☐ MEDICAID ☐ SNAP

Date: _____
Case Name: _____
Case ID: _____

AUTHORIZATION: I authorize you to release to the Division of Welfare and Supportive Services the requested information.	
Client Signature	Date

CASH CONTRIBUTION VERIFICATION

_____ has applied for assistance. In order to process the application, all income and insurance coverage must be verified. Please complete and return the information requested below to the address above. Your cooperation is appreciated.

1. Did you, or do you plan to, contribute any money directly to the above person during the months listed below?
   ☐ YES ☐ NO

   A. Please specify how much you gave, or plan to give, this person during the following months. **(Please provide receipts. They will be copied and returned to you.)**

		Actual Amount Paid	**Expect to Pay**
MM/YYYY	_____	$ _____	$ _____
MM/YYYY	_____	$ _____	$ _____
MM/YYYY	_____	$ _____	$ _____

   B. Does this person have to pay the money back to you? ☐ YES ☐ NO

   C. Do you plan to continue giving this person money? ☐ YES ☐ NO

2. Do you supply medical and/or dental insurance for _____ ?
   ☐ YES ☐ NO If YES, please complete the following information and furnish this Agency with a signed insurance claim form.

   Name, address and phone number of insurance company _____

   _____

   Policy Number _____ Date Issued _____

   Policy Holder _____
   Social Security Number

_____
Signature | Print Name | Title/Relationship | Date | Telephone Number

Address

_____